Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

Maternity Case Management

Billing Instructions

April 2001

(WAC 388-533-0350)

About this publication

This publication supersedes previous Maternity Case Management Billing Instructions.

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Related publications

- Maternity Support Services
- First Steps Child Care
- Home Health (home health visits are limited, and prior authorization **must** be received by MAA.)

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Important Contacts

A provider may contact the Medical Assistance Administration (MAA) with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. [WAC 388-502-0020(2)]

Questions about your provider number?

Call the toll-free line:
(800) 562-6188 **Press 1**

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9248
Olympia WA 98507-9248

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I obtain copies of billing instructions or numbered memoranda?

Check out our web site at:
http://maa.dshs.wa.gov

or write/call:
Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800) 562-6188

Where do I call if I have questions regarding…

Maternity case management

Maternity Case Management Program Mgr
Family Services Section
906 Plum Street SE
Olympia, WA 98504-5530
(360) 725-1655

Payments, denials, or general questions regarding claims processing, Healthy Options?

Provider Relations Unit
(800) 562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Electronic billing?

Write/call:
Electronic Billing Unit
PO Box 45511
Olympia, WA 98504-5511
(360) 725-1267

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Definitions

This section contains definitions, abbreviations, and acronyms used in these billing instructions that relate to the Medical Assistance program. The definitions are presented as a guide for the provider's use. They are not intended to be inclusive, nor are they intended to inhibit professional judgement. The criteria apply to all providers and contractors.

ADATSA/DASA Assessment Centers - Agencies contracted by DASA to provide chemical dependency assessment for ADATSA clients and pregnant women. Full plans for a continuum of drug and alcohol treatment services for pregnant women are also developed in ADATSA/DASA assessment centers. ADATSA refers to the Alcohol and Drug Addiction Treatment and Support Act. DASA is the Division of Alcohol and Substance Abuse.

Applicant - A person who has applied for Medical Assistance benefits.

Authorization - Official approval for department action. [WAC 388-500-0005]

Chemical Dependency - A condition characterized by reliance on psychoactive chemicals. These chemicals include alcohol, marijuana, stimulants such as cocaine and methamphetamine, heroin and/or other narcotics. Dependency characteristics include: loss of control over the amount and circumstances of use, symptoms of tolerance, physiologic and/or psychologic withdrawal when use is reduced or discontinued, and substantial impairment or endangerment of health, social and economic function.

Chemical Use - Chemical use means any ingestion of psychoactive chemicals or any pattern of psychoactive chemical use by any family member. Use patterns are characterized by continued use despite knowledge of having persistent or recurring social, occupational, psychological or physical problems that are caused by or exacerbated by use.

Child Care (DASA) - Child care funded through DASA for the children of pregnant and postpartum women so those women can attend outpatient alcohol or drug treatment services. DASA child care must be provided by a licensed child care agency or through an approved treatment facility or program.

Child Care - First Steps - Child care funded through the *First Steps Program* for the care of the children of pregnant or postpartum women while they attend outpatient Medicaid-covered services, need provider ordered bed rest, visit hospitalized newborns or during labor and delivery. First Steps child care may be provided by friends, certain relatives and/or neighbors, or through licensed child care agencies.

Child Protective Services (CPS) - The program within the Division of Children and Family Services authorized by statute (RCW 26.44) to receive and investigate referrals of child abuse, neglect, and exploitation.

Children's Coordinated Services (CCS) - The federal Title V program for children with special health care needs.

Children's Health Program - A state-funded full-scope health program for children 17 years of age and younger who are not eligible for a federal health program.

Client - For the purposes of this specific billing instruction, "client" refers to an applicant for or recipient (mother and newborn) of DSHS medical care programs.

Client Support, Division of (DCS) – The division within MAA responsible for:

- Client enrollments, exemptions and disenrollments in managed care plans;
- Coordination of Medicare and private insurance benefits;
- Transportation and interpreter services;
- Operation of a customer service hot-line; and
- Administration of a centralized children's eligibility section and CHIP, eligibility policy, marketing and outreach.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community and Family Health (CFH) - The state office within the Department of Health whose mission is to improve the health and well being of Washington residents, with a special focus on infants, children, youth, and prospective parents.

Community Services Office (CSO) - An office of the department [The Department of Social and Health Services (DSHS)] that administers social and health services at the community level. [WAC 388-500-0005]

Core Provider Agreement - The basic contract that MAA holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

Department - The state Department of Social and Health Services [DSHS]. [WAC 388-500-0005]

Department of Health (DOH) - The agency whose mission is to improve the health and well being of Washington residents.

Division of Alcohol and Substance Abuse (DASA) - The division in DSHS designated with the primary responsibility for addressing treatment needs of chemically dependent persons.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) - Also known as the "healthy kids" program, means a program providing early and periodic screening, diagnosis and treatment to persons under 21 years of age who are eligible for Medicaid or the children's health program. [WAC 388-500-0005]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Federal Aid - Matching funds from the federal government received by the state for medical assistance programs. [WAC 388-80-005]

Healthy Kids - Also known as the EPSDT medical service, which provides for early and periodic screening, diagnosis and treatment to a person 21 years of age and under who is eligible for those services under Title XIX of the Social Security Act.

Healthy Kids Provider - (1) A physician, advanced registered nurse practitioner (ARNP), or public health nurse certified as a Healthy Kids provider; ***or*** (2) a dentist, dental hygienist, audiologist, optometrist or ophthalmologist who is an enrolled Medical Assistance provider and performs all or one component of the *Healthy Kids* screening.

Homeless - A person without shelter or in imminent danger of being without shelter, such as an evicted person or an adolescent unable to return home. (Stewart B. McKinney Homeless Assistance Act, 1987)

Linkage - A term used to describe the networking and/or collaboration between agencies that deal with maternity case management clients in order to assure proper referral of clients and to avoid duplication of services.

Local Match - Nonfederal funds provided by local entities to match the federal Title XIX funds provided for a given program.

Maternity Case Management (MCM) - Services which will assist individuals eligible under the Medicaid state plan to gain access to needed medical, social, educational, and other services (SSA 1915[g]). Maternity case management includes the following and are done in a prescribed and accountable manner:

- Advocacy and linkage with community resources;
- Comprehensive and on-going identification of needs (medical, social and educational); and/or
- Development and implementation of a detailed plan of services and related activities for the client.

Maternity Support Services (MSS) - Preventive health services for pregnant/postpartum women including: assessment, education, intervention and counseling provided by an interdisciplinary team of community health nurses, nutritionists, and psychosocial workers, childbirth education, and authorization of child care. Community health worker visits may also be provided.

Maximum Allowable - The maximum dollar amount for which a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to:

- Categorically needy as defined in WAC 388-503-0310 and 388-503-1105; or
- Medically needy as defined in WAC 388-503-0320. [WAC 388-500-0005]

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Assistance IDentification (MAID) card – MAID cards are the forms DSHS uses to identify clients of medical programs. MAID cards are good only for the dates printed on them. Clients receive a MAID card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards or medical coupons.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly "course of treatment" available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Patient Identification Code (PIC) - An alphanumeric code assigned to each MAA client consisting of:

a) First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha or numeric character (tiebreaker).

Program Support, Division of (DPS) – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- First Steps;
- Field Services;
- Managed Care Contracts;
- Provider Relations; and
- Regulatory Improvement.

Provider or Provider of Service - An institution, agency, or person:

- Having a signed agreement with the department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the department. [WAC 388-500-0005]

Psychoactive Chemicals - Chemicals, including alcoholic beverages, controlled substances, prescription drugs, and over-the-counter (OTC) drugs, which affect mood and/or behavior. Nicotine and food are not considered psychoactive chemicals.

Refugee – The status granted by the Immigration Naturalization Services (INS) under section 101(a)(42) of the Immigration Naturalization Act (INA) to a person unwilling or unable to return to their country of nationality due to persecution or fear of persecution based on race, religion, nationality, membership in a particular social group, or political opinion.

Remittance and Status Report (RA) - A report produced by MAA's claims processing system that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

Undocumented Alien - An alien who is not lawfully admitted for permanent residence; has applied for Temporary Lawful Resident (TLR) alien status; or is not residing in the U.S. under color of law.

Usual & Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

1) The usual and customary charge that you bill the general public for the same services; or
2) If the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the state of Washington.

WIC – A special supplemental nutrition program for woman, infants, and children.

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About the Program

What is the purpose of the Maternity Case Management program?

The goals of the Maternity Case Management (MCM) program are to:

- Develop a client's self-sufficiency so she is able to appropriately use existing medical, social, and educational resources;
- Reduce the incidence of low birth weight infants and negative birth outcomes;
- Reduce the number of repeat pregnancies among adolescents;
- Reduce the incidence of child neglect/abuse;
- Increase the appropriate use of medical/social services (e.g., early and continuous prenatal care); and
- Increase parenting skills and client participation in educational opportunities (e.g., through alternative schools or job training).

What are Maternity Case Management services?

MCM services are those services which assist individuals eligible under the Medicaid state plan to gain access to needed medical, social, educational, and other services (SSA 1915[g]).

MCM includes, but is not limited to:

- Advocacy and linkage with community resources;
- A comprehensive and on-going identification of needs (medical, social and educational); and/or
- Development and implementation of a detailed plan of services and related activities for the client.

How long are Maternity Case Management services available?

MCM services are initiated upon completion of the MCM Intake Form (refer to page F.6). After MCM services are initiated, the client and her family may continue to receive services until the infant is one year old. During this time, the mother and/or infant must remain eligible for medical assistance and participate in an active service plan.

If the pregnant or parenting woman's eligibility for medical assistance ends after the 60-day postpartum period but her infant remains eligible, use the infant's PIC for billing maternity case management up to the child's first birthday.

Freedom of Choice

MCM clients have the right to choose their MCM providers, and any other MAA providers, as allowed under Section 1902(a)(23) of the Social Security Act.

1. **Option to Receive Services**
   An MCM client in the target population must have the *option* to receive MCM services and cannot be forced to receive services for which she might be eligible under Section 1915(g)(1) of the Social Security Act.

2. **Free Choice of Maternity Case Management Providers**
   MCM clients have free choice of MCM services from any qualified provider of these services statewide. **You may not limit the client to MCM providers in a given county or clinic, even if the client receives all other MAA-covered services through that county or clinic**.

3. **Free Choice of Other Providers**
   The client must have free choice of providers of other medical care.

Confidentiality, Consent, and Release of Information

A release of information is <u>not necessary</u> when:

- DSHS CSO staff are making a referral for MCM to an agency with which the department has a contract for this specific service.

- The contract agency provides DSHS with information on any services that are provided.

- Agencies on the statewide ***First Steps Provider Directory*** are exchanging health care information related to a client's pregnancy.

    1. Providers must have policies and procedures that safeguard the confidentiality of the client's records. These records must:

        a. Allow for timely sharing of information with appropriate professionals and agencies on the client's behalf; AND

        b. Ensure that confidentiality of disseminated information is safeguarded.

    2. Providers must have policies and procedures for a release of information:

        a. Prior to any disclosure of client-specific information or records including, but not limited to, treatment and testing for sexually-transmitted diseases (including HIV/AIDS), substance abuse and mental health treatment.

        b. To transfer pertinent MCM records to another MCM provider when a client changes providers. (The transferring agency is required to provide the new MCM provider with client-specific information, such as the MCM intake criteria, assessment form, and current service plan.)

        c. To transfer (with the client's permission) pertinent MCM records to the client's Healthy Options managed care plan, when applicable.

        d. That ensures that the release of information conforms to all applicable state and federal laws.

What records must be kept in the client's file?

Specific to MCM

- A completed MAA Intake Form (see page F.6);

  Documentation of the MCM intake criteria may also be recorded on the sample state form "MSS/MCM Initial Prenatal Assessment," if that is the form your agency uses.

- A completed Assessment Form;
- A service plan listing MCM **issues**, **interventions** (such as referrals to needed community resources), **outcomes**, and **service plan updates** on an on-going basis;
- The date and location of client contacts;
- A release of information signed by the client; and
- Client consent or refusal to receive MCM services.

☞ **Note:** There are occasions when a client is referred for MCM services and, after an initial face-to-face visit, the client refuses to continue services or decides to receive services from another provider.

In these instances, agencies may bill for this first visit when chart notes reflect that:

- ✓ An orientation to First Steps services was provided; and
- ✓ A baseline assessment was initiated; and
- ✓ Some intervention occurred (such as referrals to community resources).

General **[Refer to WAC 388-502-0020]**

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth [record PIC, see definition on page A.4];
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service; and
  - ✓ Plan of treatment and/or care, and outcome.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.

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Client Eligibility

Please remember! Any pregnant MAA client is eligible for Maternity Support Services. Refer to MAA's Maternity Support Services Billing Instructions for further information.

Some pregnant women have a higher risk than others for poor birth outcomes due to age, medical or mental condition, lack of access to appropriate care, and other reasons. Therefore, the targeted population for MAA Title XIX funded maternity case management is high-risk pregnant/ parenting women who have been determined eligible for Medicaid.

Who is eligible for Maternity Case Management?

[Refer to WAC 388-533-0350(2)]

To be eligible for maternity case management services (MCM), a client must present a Medical Assistance IDentification (MAID) card with one of the following identifiers:

MAID Identifier	Medical Program
CNP	Categorically Needy Program
CNP - Children's Health	Children's Health Program
CNP-CHIP	Children's Health Insurance Program
CNP – Emergency Medical Only	CNP – Emergency Medical Only

☞ **Note:** If the client is pregnant but her card does not list one of the above medical program identifiers, please refer the client to her local Community Services Office (CSO) to be evaluated for a possible change in her medical assistance program that would enable her to receive full scope maternity care.

AND…
(see next page for rest of criteria)

The client must also meet at least one of the following two criteria:
[Refer to WAC 388-533-0350(4)]

- Be 17 years of age or younger; or
- Using alcohol/drugs and/or living in an environment in which alcohol/drugs are present.

-OR-

The individual demonstrates an inability to access necessary resources and/or services, and meets at least three of the following criteria:

The client:

1. Is homeless, staying with friends and relatives on a short-term basis, or is staying in shelters;
2. Is a victim of current or recent violence (e.g., physical or sexual abuse, CPS involvement);
3. Is lacking a support system and/or involvement of partner;
4. Has medical factors related to her pregnancy outcome, such as HIV/AIDS, diabetes, hypertension, chronic illness, multiple gestation (twins, triplets), previous preterm birth, cigarette smoking (more than six per day);
5. Has two or more children, 4 years of age and under, in the home;
6. Has an eighth grade education or lower;
7. Has a physical disability;
8. Has a mental impairment/depression;
9. Received her first prenatal care after 28 weeks gestation;
10. Qualifies for refugee status (This does not include undocumented aliens; see Definition section);
11. Is 18 or 19 years of age; or
12. Has a limited English proficiency.

Are clients enrolled in a Healthy Options managed care plan eligible?

Yes! Clients whose Medical Assistance IDentification (MAID) cards have an HMO identifier in the HMO column are enrolled in a Healthy Options managed health care plan. **These clients are eligible for Maternity Case Management services through fee-for-service.** MCM services are exempt from Healthy Options managed care plan coverage and must be billed directly to MAA (see billing address in Important Contacts section).

Provider Qualifications

How does an agency qualify to become a Maternity Case Management provider? **[Refer to WAC 388-533-0350(7)]**

To qualify as a maternity case management (MCM) provider, an agency must:

- Be approved by the Medical Assistance Administration (MAA)
  (see page F.1 for Provider Pre-Application and Application Process); and
- Meet the agency and MCM qualifications listed below.

Once approved, MAA assigns a separate MAA provider number for MCM services.

Maternity Case Management Agency Qualifications

A qualified MCM agency must meet all of the criteria below:

- Is a public or private social service, health, or education agency employing staff with maternity case manager qualifications (see page D.2).
- Demonstrates linkages and referral ability with essential social and health service agencies and individual practitioners.
- Has experience working with low-income families, especially with pregnant or parenting women and their children.
- Meets applicable state and federal laws and regulations governing the participation of providers in Medicaid.

Maternity Case Manager Qualifications

A qualified maternity case manager is either:

- A professional (e.g., nurse, social worker, teacher, substance abuse counselor); **or**
- A paraprofessional under the direct supervision of a professional (e.g., nurse, social worker, teacher, substance abuse counselor);

-AND-

- Is employed by an approved MCM provider (e.g., a public or private health, social service, or education agency).

> ☞ **Note:** MAA does not consider a social services student or intern who is completing a practicuum for college course work credits a qualified employee of an MCM agency.

Maternity case managers who work with chemically abusive or chemically dependent clients must have a basic understanding of the course of addiction and effective interaction between chemically dependent persons and helping professionals. Maternity case managers must document this understanding through:

- Verification of academic work;
- Workshops or seminars on chemical dependency;
- Knowledge of the physiological actions of alcohol and other drugs; and/or chemical dependency in the client's family; or
- Field experience in working with substance abusive clients.

This documentation must be kept in the MCM employee's personnel file.

In addition, the following specific minimum requirements must be met:

If the maternity case manager is a(n):

- **Nurse**: Bachelor of science in nursing (BSN) or a registered nurse with two years experience in parent-child nursing.

- **Social Service Worker**: Bachelor's or master's degree in social work, behavioral sciences or related field with one year of experience in community social services, public health services, or related field. Other master's or bachelor's degrees may be substituted with two years of closely related work experience in community social services, public health services, or related field.

- **Paraprofessional**: Associate degree in behavioral sciences or related field and two years of closely related work experience. Qualifying experience may be substituted, year for year for education. Must work under the direct supervision of a qualified registered nurse or social service worker.

  ☞ **Note:** College credits/course work may not be substituted for the required work experience.

- **Employee of a school district**:

  ✓ Certified teachers with specialized training and experience in parenting education, child development, nutrition, family resource management, health, interpersonal relations and crisis intervention; **or**

  ✓ Educational staff associates with certification as a school counselor, a school psychologist, a school nurse or a school social worker.

- **Substance abuse counselors**: The requirements for qualified or certified counselor as defined in chapter 388-805 WAC must be met.

If an agency needs an exception to MCM staffing qualifications due to special needs or circumstances, please send a written exception request to the MAA Maternity Case Management Program Manager. (See *Important Contacts* for address.)

☞ **Note:** If an unqualified employee provides MCM services, MAA considers this an erroneous billing and recoups any resulting overpayment during an agency Medicaid audit.

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Provider Responsibility

Referrals

MCM providers must establish and maintain a referral process with pertinent individuals and agencies for appropriate services, in order to avoid duplication of services to clients.

Referrals for MCM may come from a number of sources:

1. **Community Services Offices (CSOs)**
   Whenever possible, the DSHS CSO *First Steps* social worker will assess each pregnant MAA client. Those eligible for maternity case management must be referred and assisted in choosing an approved MCM provider. Information from the CSO assessment should be shared with the MCM contract agency.

   Since DSHS contracts for MCM services, information necessary to make a referral may be shared by the CSO with these contract agencies without a release of information form. The contract agency must notify the CSO within a month of referral (sooner if possible) that the pregnant woman has been successfully contacted. If a contract provider is not available or not able to see the woman within a month of referral, MCM services may be available through the CSO or another MSS/MCM provider.

2. **Other Community Agencies**
   Referrals for maternity case management may be made to an approved provider by any other community agency. If Medicaid eligibility has not been established, a referral should also be made to the CSO.

Provider Linkage Requirements

1. The provider must develop or use an existing system to receive referrals from other professionals who are in contact with MAA clients who require assistance in meeting health care, education, and social service needs.

2. The provider should inform community agencies, local providers of prenatal care, and other referral sources of the availability of MCM services.

3. Evidence of provider compliance with linkage requirements includes formal written agreements with agencies in the community that provide health care, education and social services. (These agreements must include telephone numbers and contact names.)

4. In addition to the general linkage requirements, the MCM agency must have a written working agreement with the local Community Services Office (CSO) or the DSHS Economic Services Regional Office. See the Application Process on page F.1 and sample "Memorandum of Agreement" on page F.5.

5. The MCM agency is encouraged to establish written interagency agreements or other formal linkages with the following providers/agencies in its service area:

   a. Maternity Support Service (MSS) provider(s) (e.g., community clinics, public health department).

   b. The local ADATSA Assessment Center and alcohol/drug service system agencies.

   c. Education and job training services, (e.g., school districts, community colleges that offer basic education/job training).

   d. Prenatal care providers or community referral system(s).

   e. Primary health care providers.

   f. Other MCM agencies.

   g. Family planning agencies.

   h. Indian health centers.

   i. Mental health centers.

   j. Women, Infant, and Children (WIC) food supplement program.

   k. Community health clinics.

   l. The local Division of Children and Family Services (Children's Protective Service [CPS], Child Welfare Services [CWS], foster care, and other related children's services).

   m. Division of Developmental Disabilities (DDD) (e.g., local offices).

   n. Agencies coordinating *Child Profile* database (e.g., local health departments).

   o. Other community agencies.

Intake/Assessment—Identifying the Client's Needs

[Refer to WAC 388-533-0350(3)]

The MCM Intake Form (see page F.6) must be completed:

a) During the eligible client's pregnancy;
b) By the day of discharge from the hospital of the eligible birth mother; or
c) By the day of discharge from the hospital of the eligible newborn child.

Client needs are identified through the systematic collection of data relating to physical, environmental, psychosocial, developmental, educational, behavioral, emotional, and mobility needs. This is an ongoing process involving the collection and processing of data with each family contact. Data sources include, but are not limited to:

- Client/family interviews; and
- Intake/assessment records from other service providers (e.g., CSO First Steps social workers, WIC, MSS and prenatal care providers).

In the intake/assessment process, the maternity case manager must identify the client's immediate needs. When an intake/assessment is conducted by a paraprofessional, the nurse or social service worker providing supervision must review and initial the intake/assessment document.

The maternity case manager must make appropriate referrals and/or assist the client to obtain the identified services needed in the intake process. If needed services are not already in place, the following referrals are required:

- To a prenatal care provider or community referral system. (The maternity case manager must work in cooperation with the primary care provider (PCP) when the client is enrolled in a Healthy Options managed care plan.)

- To an MSS agency for a nursing, nutrition and/or psychosocial assessment; and

- To an ADATSA Assessment center for a chemical dependency assessment, if chemical use by client is identified/suspected and the client chooses to have an assessment completed. This must follow CSO verification of continued Medicaid eligibility.

The maternity case manager must use the following demographic and needs information provided by CSO *First Steps* social workers, WIC, MSS, and/or prenatal care providers whenever possible. (see page E.8 for *Client Characteristics and Needs Assessment*.)

- Client characteristics
- Prenatal/maternity
- Substance use and chemical dependency treatment
- Sexually-transmitted disease screening and treatment
- Primary and preventive health services and education
- Pediatric care
- Sexual decision making
- Nutrition counseling
- Adoption counseling
- Education/vocational training
- Economic/housing
- Role/relationship
- Child care
- Other: Need for assistance in obtaining services (e.g., transportation or consumer/homemaking skills)

Service Planning - Documentation

A service plan must be developed that may include additional information and clarification provided by the client/family.

☞ **Note:** MCM is a family-based intervention program that includes spouse/partner and other children's needs.

Planning activities should determine what resources are available to meet the client's needs in a coordinated, integrated fashion. The service plan will provide for transition to independence, including an expected date and method for achieving this transition. Whenever possible, make sure family members and appropriate professionals are included in the planning process.

An interdisciplinary team approach must be used as much as possible by the maternity case manager, the client, and MSS team members. MSS agencies are required to case conference on MCM-eligible clients. Therefore, MCM staff are asked to participate in MSS/MCM team conference whenever possible. If it is not possible, then, at a minimum, share your written MCM plan with the MSS agency. When a paraprofessional is developing a service plan, the nurse or social service worker providing supervision must review and initial the service plan at least quarterly or more often, if needed.

1. The maternity case manager, along with the client and her family in cooperation with the interdisciplinary team (when available), will develop a written MCM service plan identifying:

    a. Each MCM issue/problem to be addressed;
    b. Interventions (such as referrals, linkages, and advocacy activities);
    c. Identification of respective responsibilities (facilitator of the intervention(s)); and
    d. Outcomes (including dates).

2. The maternity case manager, the client and her family must review and update the service plan at each billable visit, collaborating as necessary with other professionals.

Implementing the Service Plan

1. The maternity case manager must make referrals in a coordinated and planned manner or assist the client with self-referral to needed resources.

2. The maternity case manager must maintain at least one in-person contact a month with the client and provide advocacy as needed to:

    a. Encourage cooperation in implementing the service plan;
    b. Resolve problems which interfere with active participation in the plan (e.g., transportation, child care); and
    c. Ensure that services are meeting the client and family's needs.

3. The maternity case manager must maintain contact with other agencies involved in implementation of portions of the service plan to:

    a. Ensure coordinated service delivery;
    b. Share information;
    c. Work out any coordination problems that might arise; and
    d. Avoid duplication of services.

4. The maternity case manager must help the client and her family to find an appropriate primary care provider for ongoing health care as needed. (The maternity case manager must work in cooperation with the assigned primary care provider when the client is enrolled in a Healthy Options managed care plan.)

Advocacy

Advocacy-related activities are provided to help the client's family achieve the goals of the service plan, particularly when resources are inadequate or the service delivery system is nonresponsive. The maternity case manager must negotiate or otherwise assist the client in accessing appropriate services.

1. The maternity case manager must serve as a client advocate and intervene with agencies or individuals to help clients receive appropriate benefits or services.

2. The maternity case manager must assist the client and her family to accomplish necessary tasks such as:

    a. Filling out pertinent forms;
    b. Obtaining necessary documentation or authorization;
    c. Using MAA's brokered transportation to MAA-paid appointments; or
    d. Finding other transportation to non-medical services.

3. The maternity case manager must consult with service providers and professionals to utilize their expertise on the client's/family's behalf.

4. The maternity case manager must assist the client and her family to identify stress arising from the client's problems and facilitate any necessary changes.

Accountability

Activities that ensure the client has received services geared toward successful completion of the service plan and transition to independence are:

1. Maintaining monthly face-to-face contact with the client and her family to monitor implementation of the service plan.

2. Participating in an ongoing assessment of the client's and family's needs to determine if expected outcomes are reached and to ensure implementation and/or adjustment of the service plan, as needed.

3. Maintaining files and forms that document MCM activities and services received which are used in service planning and subject to audit. (See "What records must be kept in the client's file?" on page B.4.)

Terminating MCM services when:

a. The client is able to access systems to meet the family's needs;
b. Neither the woman or her child is eligible for Medical Assistance (up to the child's first birthday; or
c. There is no longer an active service plan.

Given the mobility of the target population, MCM agencies must take care to not terminate service prematurely.

Note: When a paraprofessional is developing a service plan, the nurse or social service worker providing supervision must review and initial the service plan at least quarterly, or more often if needed.

Client Characteristics and Needs Assessment

1. CLIENT CHARACTERISTICS

a. Date of birth;
b. Race;
c. Expected delivery date (EDD);
d. Date of birth of youngest child;
e. Number of children in the home;
f. Risk factor(s) indicating a need for maternity case management;
g. Marital status;
h. Client's education level; and
i. Physical or mental impairment.

2. PRENATAL/MATERNITY

a. Pregnancy verification;
b. Access to primary medical provider for maternity care;
c. Identification of high-risk medical conditions such as diabetes or high blood pressure;
d. Knowledge of and need to explore prenatal care alternatives and the resources available;
e. Prenatal care education and counseling;
f. Number of previous pregnancies;
g. Prior pregnancy outcomes; and
h. Client's attitude toward this pregnancy.

3. SUBSTANCE USE TREATMENT AND EDUCATION

a. Identify chemical use/abuse and tobacco use by the client or its presence in her environment, including:

- Tobacco
- Alcohol
- Marijuana
- Cocaine
- Crack
- IV/needle use
- Prescribed drugs
- Heroin
- Other

b. Provide referral to education and counseling on chemical use/abuse and tobacco use, and/or eating disorders issues.

c. Refer the client for an ADATSA assessment for treatment services, if needed.

4. SEXUALLY-TRANSMITTED DISEASE SCREENING AND TREATMENT

a. Provide referral to community service providers for education and/or counseling on risk for AIDS;

b. Provide referral to community service providers for education and counseling on sexuality and family life; and

c. Provide referral to community service providers for screening or treatment of sexually transmitted diseases.

5. PRIMARY AND PREVENTIVE HEALTH SERVICES AND EDUCATION

a. Help the client to establish an ongoing relationship with a primary care provider;

b. Provide referral to community service providers for basic education given to the client on preventive health care, ongoing health maintenance practices, safety, and nutrition; and

c. Refer the client for psychosocial assessment and counseling.

6. PEDIATRIC CARE

a. Help the client to establish an ongoing relationship with a primary care provider for her baby;

b. Provide knowledge of the importance of medical care, immunizations, well child exams/Healthy Kids checks; and

c. Provide referral to community resources to include:

- Education on infant growth and child developmental norms; and
- Parenting classes.

7. SEXUAL DECISION-MAKING/UNINTENDED PREGNANCY PREVENTION

a. Refer the client to community service providers for sexual abuse prevention or victimization counseling, if needed;

b. Refer the client to community service providers for counseling and information to the client on the responsibilities of sexuality, relationships, and parenting;

c. Provide referral to community service providers for assertiveness training and promote the development of high self-esteem; and

d. Provide referral to community service providers for family planning information/services, e.g., MSS provider, CSO Family Planning Social Worker.

8. NUTRITION COUNSELING

a. Refer the client to community resources such as the Women, Infant and Children (WIC) program and the food stamp program;
b. Refer the client for nutrition assessment and counseling; and
c. Refer the client to community resources for counseling on eating disorders, and identify treatment options.

9. ADOPTION COUNSELING

a. Provide information on adoption/open adoption; and
b. Provide referral to an adoption program specialist, if necessary.

10. EDUCATION/VOCATIONAL TRAINING

a. Inform the client about her options for completion of education or vocational training for job placement, if appropriate;
b. Provide referral to community resources such as a job training program;
c. Provide referral to remedial or special education program, if appropriate; and
d. Consult with CSO WorkFirst Case Manager, if client is receiving a TANF (Temporary Assistance for Needy Families) grant.

11. ECONOMIC/HOUSING

a. Explore employment issues;
b. Seek financial assistance; and
c. Find housing arrangements.

12. ROLE/RELATIONSHIP

a. Assess support system;
b. Assess freedom from violence or threat of violence;
c. Make provider referrals to community resources for domestic violence and safe housing, if appropriate; and
d. Make provider referral to MSS Psychosocial Worker, if within 60 days post-pregnancy.

13. CHILDCARE

The maternity case manager screens the client's circumstances to determine the need for childcare. If childcare is identified as a need and that resource is not available to the client, the case manager can authorize an appropriate number of time-limited First Steps Childcare billing forms. The purpose of offering childcare to MAA-eligible pregnant/parenting women is to improve birth outcome and to remove one of the barriers in accessing medical care.

The client may be screened and receive authorization for First Steps childcare throughout her pregnancy and up to 60 days post-pregnancy for the following reasons:

1. Client is attending MAA-covered outpatient pregnancy/postpregnancy services;
2. Client is on provider-ordered bedrest;
3. Client is in labor and delivery; or
4. Client needs to visit a hospitalized newborn.

MAA approval is required for First Steps Childcare bedrest, and visiting a hospitalized newborn. For further details and to obtain the billing form, see the First Steps Childcare Billing Instructions. First Steps Childcare staff can be reached by calling: 1-888-889-7514.

MAA expects all MCM and MSS team members who authorize childcare to read and be familiar with the First Steps Childcare billing instructions. The detailed childcare information is also included in the ABCs of First Steps Manual under the "First Steps Childcare" tab sent to all First Steps agencies.

14. OTHER

Assess the client's need for assistance in obtaining services such as transportation, MAA covered interpreter services, and consumer and/or homemaking skills.

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MCM Provider Pre-Application and Application Process

Pre-Application

To become a maternity case management (MCM) provider, a completed pre-application is required. The pre-application form asks interested agencies to complete a Community Needs Assessment, and to review enclosed materials that will assist the agency in determining their readiness and capability to provide MCM services. The MCM Program Manager is available to give technical assistance to potential MCM providers.

- ✓ To request a MCM-only pre-application packet, call the MCM Program Manager at (360) 725-1655.
- ✓ To request a MSS/MCM pre-application packet, call the administrative assistant at the Department of Health at (360) 236-3505.

The pre-application requests the following information:

1. The geographic area that you plan to serve (counties, city areas).
2. The sites where you plan to offer MCM services, include a contact person, address and telephone number for each.
3. Your staff capability for providing MCM services (Refer to the MCM Billing Instructions for staff requirements). Complete the Personnel Roster that is sent as part of the pre-application packet.
4. Community Needs Assessment

   A. Are there other MSS/MCM providers in your area? Review the directory of agencies. Have you met with each of the providers in your county to explore your interest or intent to provider MCM services? If you have not, how will you coordinate with them? Have you attended a First Steps providers' meeting?

   B. Will the opening of your site result in a duplication of service?

      - Provide an estimate of the MCM population your agency expects to serve. List the total number of Medicaid births in your area. Compare this to the women you expect to serve.
      - Consider in this assessment that some clients decline services.
      - Please give a brief narrative of need and justification for developing an MCM site in your area. This should be based on the above information.

5. The experience your agency has in providing community health and social services to woman, infants and families.
6. Special populations, such as teens, homeless, migrants, the disabled or ethnic minorities. Please include the percentage of total clients in these categories.
7. The inter/intra-referral network that you propose to use for MCM program operations. List the local agencies to which you would make referrals.
8. Other funding sources beyond Medicaid to support MCM program.

This pre-application must be signed by both the administrator and the coordinator of the program.

After completion, send the pre-application documents to:

MCM Program Manager
Medical Assistance Administration
PO Box 45530
Olympia WA 98504-5530

The MCM Program Manager will contact the provider by letter indicating the next step in the application process. An interested agency must not proceed to the MCM application phase without approval of the pre-application, as indicated by a written notice from the MCM Program Manager.

Application

Once the pre-application phase has been completed and approved by MAA, interested agencies are free to complete the MCM application requirements detailed below. An MAA Maternity Case Management (MCM) program manager is available to provide technical assistance and consultation throughout the application process. (See the contact information on the next page.)

The application must include the following:

1. A completed Maternity Case Management (MCM) Provider Application (see page F.4).

2. A brief narrative description of how your agency plans to deliver MCM services.

3. A *client flow chart* that shows:

   - The receipt of a referral through the identification of needs
   - Referrals to needed resources
   - The team approach used in development of the service plan
   - How the service plan will be implemented
   - Linkage with the prenatal care provider and support services
   - Case closure/transition
   - Transfers to other maternity case managers

4. A written working agreement with your local CSO. The agreement must be signed by the administrator of your agency and the CSO. If your agency works with more than one CSO, *one agreement* can be signed by the Economic Services Regional Administrator (or designee).

   ☞ **Note:** MAA has provided a sample working agreement for your convenience on page F.5. It can be amended to reflect specific needs.

5. A copy of your agency's:

   a. Intake/assessment form;
   b. Service plan; and
   c. Client contact log.

   If you do not have such documents, samples are enclosed in the application packet for your use and/or modification. Any documents you plan to use must be submitted to MAA for approval.

6. A completed MAA Core Provider Agreement (this is sent in the application packet).

Submit items 1-5 above to:

MCM Program Manager
Medical Assistance Administration
PO Box 45530
Olympia WA 98504-5530
(360) 725-1655

Maternity Case Management Provider Application

Part A: General Information

Name of Agency:
Official Address: _____ _____ _____
Main Office Telephone Number: ( )
Chief Administrative/Executive Officer:
Maternity Support Services Coordinator: _____ **Telephone:** _____
Date Application Submitted:

Do You Have a Medicaid Case Management Provider Number: [ ] Yes [ ] No
Medicaid Case Management Provider Number(s): _____
Type(s): _____ (e.g., HIV/AIDS, Child Protective Services-Nursing Intervention Program)

Geographic area for Maternity Case Management services:
If your agency has more than one site, you must provide information on the address, telephone number, contact person and service area for each site.

OFFICIAL USE ONLY	
APPLICATION APPROVED: [ ] Yes [ ] No	**Date:**
NAME OF REVIEWER(S):	

MEMORANDUM OF AGREEMENT

between

Maternity Case Management Provider and Community Services Office

1. The Community Service Office (CSO) will provide the Maternity Case Management Provider with the name and telephone number of a CSO contact person. The CSO contact person will serve as a coordination point for determining TITLE XIX eligibility, general information about CSO services, and problems.

2. The Community Service Office will provide the Maternity Case Management Provider with a list of services and a basic understanding of services available through the CSO. The understanding will include a discussion of all situations that would normally require a case status update (e.g., change in status which made the client ineligible, case manager unable to locate the client.)

3. The CSO contact person and the Maternity Case Manager will schedule regular case staffing as needed.

4. The Maternity Case Management Provider will keep the CSO contact person apprised of staff providing case management services, population being provided case management services, and geographic area of case management service provision.

Maternity Case Management Agency

_____
Name/Title Agency Director

_____
Address

_____
Telephone

_____
Date

_____
Maternity Case Manager Coord./Phone

Community Services Office (CSO) or Community Service Division Regional Office

_____
Name/Title CSO Administrator or Regional Office Contact

_____
CSO Contact Person - First Steps or Regional Office Contact

_____
Telephone

_____
Date

Maternity Case Management Intake Form
[DSHS Form # 13-658(X)]

To order this form, go to the following link:

http://www.wa.gov/dshs/dshsforms/index.html#electronic

Billing

Maternity case management is considered family-based intervention. Only <u>one</u> monthly Title XIX [targeted] case management fee for a pregnant/parenting woman and her family is allowed.

Chemically Dependent Client

Use state-unique procedure codes **0076M or 0077M** to bill for pregnant or parenting women who are chemically dependent. The maternity case manager must document the following circumstances in the client's MCM record:

- Indications of alcohol and/or drug use by the woman, <u>OR</u>
- Indications of the presence of alcohol/drug use in the client's environment. (When billing these procedure codes, the service plan must include activities that address alcohol/drug issues.)

Refer women who are using alcohol and/or drugs to the county ADATSA Assessment Center for evaluation. A woman does not necessarily have to follow through with a drug treatment plan in order for you to bill at the higher rate. You must document your efforts to encourage the client to follow through with treatment.

Child Removed from the Mother's Home

Continue to bill for MCM services if the parenting client has had her infant removed from her custody, so long as:

- The plan is for her infant to return to her custody and she is participating in an active service plan, AND
- Either the mother or infant is eligible for Medical Assistance.

The MCM provider may work with the custodial relative or the foster home family, as appropriate. Documentation of all MCM activities must be written on the active service plan or cross-referenced to a dated progress note (please consult with a CPS Social Worker if providing MCM services to a foster home family and infant).

Mileage and field visit expenses are included in the reimbursement of each state-unique procedure code.

Fee Schedule

Bill only ONE (1) of the following procedure codes per client/per family, per month. Clients may have one Title XIX case manager at a time (e.g., Maternity, Child Protective Service/Public Health Nurse, HIV/AIDS).

State-Unique Procedure Code	Description	Maximum Allowable Fee Effective 7/1/02*
0076M	Monthly case management fee for at least one **in-person contact** with the chemically-dependent** pregnant woman with no children living with her.	$101.90
0077M	Monthly case management fee for at least one **in-person contact** with the chemically-dependent** pregnant and/or parenting woman with children living with her.	113.20
0079M	Monthly case management fee for at least one **in-person contact** with the pregnant woman with no children living with her.	71.35
0080M	Monthly case management fee for at least one **in-person contact** with the pregnant and/or parenting woman with children living with her.	83.20
0081M	Fee for reasonable **documented** attempts to contact client, but no in-person contact was made during the month (billing for this code is limited to the following circumstances: numerous telephone calls without response; agency letter to the last known address returned undeliverable; a home visit was attempted but no one answered the door; or the client did not show for a scheduled appointment). This procedure code may be used when an initial MCM assessment was completed **or** not completed. This procedure code is intended for outreach purposes and will be allowed only once in a three-month period during the client/baby's eligibility for MCM services (see page E.7).	12.00

***** Vendor rate increases occur on July 1st if authorized by the legislature. Check your most recent Numbered Memorandums issued in June of each year for new rates, or check MAA's web site at: http://maa.dshs.wa.gov (Numbered Memorandum link), or call MAA's Maternity Case Management Program Manager at (360) 725-1655.

****** Bill the appropriate state-unique procedure code (0076M or 0077M) when the active service plan includes identified needs/issues relating to alcohol or drug use by the client or use by others in her environment.

What is the time limit for billing? [Refer to WAC 388-502-0150]

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to obtain an ICN for an **initial claim** within 365* days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

- MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

- Providers may **resubmit, modify, or adjust** any timely initial claim, <u>except</u> prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  Note: MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

  *** First Steps Child Care billing forms must be submitted within 90 days of care by the child care provider.**

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1 **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

2 **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill MAA.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee**.**

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

General Guidelines:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

  If you need preprinted red and white HCFA-1500 claim forms, **call 1-800-562-6188.**

- **Do not use red ink pens, highlighters, "post-it notes," or stickers** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges.

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

Field Description/Instructions for Completion

1a. **Insured's I.D. No.**: Required. Enter the MAA alphanumeric Patient (client) Identification Code (PIC) exactly as shown on the client's monthly Medical Assistance IDentification (MAID) card. The PIC consists of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available)
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY)
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
d) An alpha or numeric character (tiebreaker)

For example:

1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: When applicable, show the last name, first name, and middle initial of the insured if it is *different from* the name shown in *field 4*. Otherwise, enter the word *Same*.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.
9b. Enter the other insured's date of birth.
9c. Enter the other insured's employer's name or school name.
9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, HO or Healthy Options First Steps, and Medicare, etc., are inappropriate entries for this field.

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: When applicable. This information applies to the insured person listed in *field 4.* Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payer of last resort.

11a. **Insured's Date of Birth**: When applicable, enter the insured's birthdate, if different from *field 3.*

11b. **Employer's Name or School Name**: When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using a 6-digit or 8-digit date of service. (Example: 040801 or 04082001) **Please indicate the actual MCM billing date, not the entire month.**

Do not use slashes, dashes or hyphens to separate month, day year.

24B. **Place of Service**: Required. Enter a **3** for the Place of Service.

24C. **Type of Service**: Required. Enter a **3** for all services billed.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate procedure code from these billing instructions.

24E. **Diagnosis Code**: Required. Enter V99.1.

24F. **$Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: Required. Enter the correct number of units. Use only whole numbers, not fractions.

25. **Federal Tax ID Number: Leave this field blank.**

26. **Your Patient's Account No**.: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the total amount of billed charges. Do not use a dollar sign or decimal point.

29. **Amount Paid**: If you receive an insurance payment or client paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use a dollar sign or decimal point or put Medicare payment here.

30. **Balance Due**: Required. Enter dollar amount owing (equal to field 28 value minus field 29 value). Do not use a dollar sign or decimal point.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Put your *Name, Address,* and *Phone #* on all claim forms.

Group: **Enter the DSHS provider number assigned to you by MAA.**

HCFA-1500 Claim Form

(See separate file)

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